Roctavian
(Valoctogene roxaparvovec)

Policy Number: 070

<table>
<thead>
<tr>
<th>Authorization Required</th>
<th>Commercial and Qualified Health Plans</th>
<th>MassHealth</th>
<th>Medicare Advantage</th>
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Roctavian is an adeno-associated virus 5 vector-based gene therapy indicated for the treatment of patients with Hemophilia A (congenital Factor VIII [FVIII] deficiency).

Criteria

1. Criteria for Initial Approval
   Authorization of a single treatment may be granted to biologic male (or male assigned at birth) members 18 years of age or older for treatment of severe Hemophilia A (endogenous FVIII activity ≤1 IU/dL or ≤1% of normal) when ALL of the following criteria are met:
   A. Requires treatment with one of the following:
      i. Currently use FVIII prophylaxis therapy AND has had > 150 previous exposure days of treatment with FVIII protein within their lifetime.
      ii. Currently use Hemlibra (emicizumab).
   B. The member is not currently receiving immunosuppressive therapy.
   C. The member does not have any active malignancies.
   D. The member has no history of thrombosis or thrombophilia.
   E. The member has no contraindications to treatment with steroids and / or tacrolimus, or mycophenolate, if needed.
   F. The member has no history of mannitol hypersensitivity.
   G. The member has not received Roctavian previously.
   H. No other known bleeding disorders, besides hemophilia A.
   I. The following require documentation¹:
      i. Annualized bleeding rate (ABR)
      ii. FVIII activity level
      iii. FVIII inhibitor level
      iv. Neutralizing Antibody to AAV5 by a test that is FDA-authorized for selection of patients for Roctavian therapy.
      v. Creatinine
      vi. AST, ALT, bilirubin, alkaline phosphatase (ALP)
      vii. Serologic testing for HIV, hepatitis B, and hepatitis C
      viii. Weight
   J. The member must have no evidence of factor VIII inhibitor at screening, defined as < 0.6 Bethesda units.

¹ Baseline ABR will be documented for the purposes of outcomes monitoring and shall have no bearing on the decision to approve or deny.
i. Individuals with a history of transient VIII inhibitor must document at least 6 months since testing positive, with at least 2 negative VIII inhibitor tests during that period.

K. The member does not have Neutralizing antibody to AAV5.

L. The member has adequate renal function as evidenced by BOTH of the following:
   i. Estimated creatinine clearance of at least 30 mL/min.
   ii. Creatinine ≤ 2 times the upper limit of normal.

M. The member does not have liver function test values (ALT, AST, bilirubin, ALP), greater than 2 times the upper limit of normal or evidence of stage 3-4 cirrhosis determined by hepatic ultrasound and elastography, unless a consulting hepatologist has assessed the member as being eligible to undergo treatment with Roctavian.

N. The member does not have active infection, chronic or active hepatitis B or C, or immunosuppressive disorder including HIV.
   i. If member has had active infection or recent treatment for Hepatitis C, there must be evidence of Hepatitis C eradication following treatment.

O. Additional courses of therapy are considered experimental and investigational.

2. Dosing and Administration
   - The recommended dose is a single dose, given intravenously, containing \(6 \times 10^{13}\) genome copies (gc) per kilogram of body weight. Appropriate dosing should follow the package insert.

3. Duration of Therapy
   - Single treatment course must be given within three months of approval.
   - Additional courses of therapy are considered experimental/investigational.

4. Facility Criteria
   - The medication is prescribed by a hematologist.
   - The treatment will be administered at a Comprehensive Hemophilia Treatment Center

**Medicaid variation**
Mass General Brigham Health Plan uses the MassHealth Drug List for coverage determinations for members of the MGB ACO. Criteria for Roctavian are found in Table 80: Anti-Hemophilia Agents.

**Medicare Variation**
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan’s medical policies are used for coverage determinations. **At the time of Mass General Brigham Health Plan’s most recent policy review, CMS has no NCD or LCD for Roctavian.**

**CPT/HCPC Codes**

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<tr>
<th>Authorized CPT/HCPCS Codes</th>
<th>Code Description</th>
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<tr>
<td>J1412</td>
<td>Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal (2 \times 10^{13}) vector genomes</td>
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**Effective**
December 2023: Effective Date.

References


WFH Treatment Guidelines 3ed, Chapter 2 Comprehensive care of hemophilia